SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: ELIGIBILTY FOR SERVICES
	Subject: High Risk Intake

Reference: ARM 37.40.1005 and ARM 37.40.1114

PURPOSE

The high risk intake is utilized for members who need services immediately for the purpose of maintaining their health and safety.

PROCESS

1. Community First Choice/Personal Assistance Services (CFC/PAS) provider agency receives a referral where implementation of services is essential to:

    a. Prevent institutionalization,

    b. Facilitate a discharge from an institution, or

    c. Resolve a hazardous home situation that places the member at high risk.

2. Medicaid eligibility is validated by the provider agency.

3. The CFC/PAS provider agency sets up an in-person home visit with the member and Personal Representative (PR), when applicable, to develop a temporary authorization, which is documented on the Service Plan (SLTC-175).

    a. The Plan Facilitator **does not** need to be present at this visit.

    b. The visit may take place in the hospital or nursing home.

4. The provider agency program oversight staff must document the scope (tasks and total time) and need for these services on the Service Plan (SLTC-175). The Service Plan should be marked to indicate, “High Risk,” and “Temporary.” The Service Plan must include the Service Plan Schedule. At the visit the provider must also obtain a signed copy of the Member/PR Agreement (SLTC-159/166) and educate the member/PR about obtaining the Health Care Professional (HCP) Authorization form (SLTC-160).

a. The provider agency can only authorize Activities of Daily Living (ADL), shopping, household tasks, and laundry. The services must fall within the parameters of the CFC/PAS program.

b. Community Integration, Correspondence Assistance, Yard Hazard Removal, Health Maintenance Activities (HMA), and Personal Emergency Response System (PERS) may not be authorized on a high-risk intake.

c. Attendant services may not begin until the HCP Authorization form (SLTC-160) is completed and signed by the HCP.

d. The member/PR has 48 hours to implement services following the high-risk intake visit. If the high risk cannot be implemented in that time frame the agency should document the reason why and the agency's attempts to meet the 48 hour guideline.

e. The Service Plan acts as the authorizing document until MPQH has completed their intake process.

5. When the provider agency completes the high risk intake, the agency must complete the Referral form (SLTC-154) and fax it to MPQH within 48 hours. The agency must indicate "High Risk" on the form, provide the reason for the high risk intake, and complete the box on the bottom of the form documenting the date services were instituted, the number of days biweekly that services are provided, and the number of units of services that are provided biweekly. The information on the bottom of the form should correspond to the information on the member's High Risk Service Plan.

6. MPQH receives the referral and follows the process for initial admissions (Refer to SD-CFC/PAS 411) and sends the Overview and Service Profile (SLTC-154/155) or Pre-Screen to the provider and Plan Facilitator within 10 working days.

    a. If the member does not meet capacity for directing their care MPQH notify the agency. The member has 30 days from the date of denial to select a personal representative or transition to agency-based services.

7. If the MPQH Service Profile is different from the provider agency's Temporary Service Plan, the provider agency must notify the member and complete an amended Service Plan within 10 working days upon receiving the MPQH Service Profile.

a. Provider agency will not be penalized when the amount of time on the temporary service authorization exceeds MPQH's authorization unless services are provided outside the scope of the program. The Department will recover payment for services delivered outside the scope of the CFC/PAS program for a high-risk intake.

b. If the MPQH Service Profile includes authorization for Health Maintenance Activities (HMA) the member/PR must obtain a new Health Care Professional Authorization form with the HMA tasks included on the form prior to delivering HMA services.

PERSON CENTERED PLAN

Once the provider agency receives the MPQH Service Profile, the provider agency must determine who the member's Plan Facilitator is and complete/receive the PCP form. For more information regarding the role of the Plan Facilitator in a high-risk intake, refer to CSB-1108.

1. The member must have a PCP form (SLTC-200) completed within 10 working days of MPQH faxing the Service Profile to the provider agency in order to continue receiving CFC/PAS services.

2. If the provider agency is the Plan Facilitator; the agency has 10 working days to schedule the Person Centered Planning (PCP) visit in the member's home. If the agency Plan Facilitator is a different person from the oversight staff, the Plan Facilitator must attend the visit and complete the PCP form (SLTC-200). The provider agency oversight staff must be present at the PCP visit to update the Service Plan, as needed, based on the member preferences captured on the PCP form.

    a. The Plan Facilitator must provide the member with a copy of the CFC/PAS Handbook prior to the PCP meeting.

    b. During the PCP meeting the Service Plan must be signed by the Plan Facilitator and the PCP form must be signed by the provider agency oversight staff. The member/PR must also sign both forms.

    Note: The provider agency Plan Facilitator and program oversight staff may be the same person.

3. If the case manager is the Plan Facilitator, the provider agency must contact the case manager upon receiving the MPQH Service Profile and notify the case manager of the high risk referral, fax the temporary CFC/PAS Service Plan, and determine the month of the annual case manager meeting.

a. The Case Manager Plan Facilitator has 10 working days upon receiving notification from the agency to complete the PCP form.

b. The provider agency and Plan Facilitator have two options for completing the CFC/PAS PCP process. The Case Manager Plan Facilitator should contact the member to discuss the options and obtain the member's preference.

   Note: The provider agency and Plan Facilitator should document the member's preference for the option that is selected prior to implementing that option.

   i. Option 1: The member, provider agency, and Case Manager Plan Facilitator have the option of conducting a coordinated PCP visit within 10 working days of receiving the MPQH Service Profile to complete the PCP form and update the CFC/PAS Service Plan accordingly. If the member has a PR the PR must be at the visit.

      a. During the visit the PCP Form must be signed by the provider agency oversight staff, Plan Facilitator, and member/PR.

      b. If the high-risk CFC/PAS Service Plan has to change as a result of the MPQH Service Profile and/or the PCP form, the provider agency oversight staff must complete a new Service Plan and must be signed by the provider agency oversight staff, Plan Facilitator, and member/PR.

      c. If the high-risk CFC/PAS Service Plan does not need to be changed as a result of the MPQH Service Profile and/or PCP form, the Plan Facilitator must sign the form during the PCP coordinated visit.

   ii. Option 2: The member, provider agency, and Case Manager Plan Facilitator have the option of coordinating the CFC/PAS PCP process with the member over the phone. The Case Manager Plan Facilitator must complete the PCP form over the phone with the member within 10 working days of receiving the MPQH Service Overview and Profile.

The Case Manager Plan Facilitator must obtain the provider agency and member's signature. The PCP form must have the required signatures within 30 days of the case manager receiving the MPQH Service Overview and Profile.

a. If the provider agency does not receive the PCP form within 30 days, the provider agency must follow-up with the Case Manager Plan Facilitator and document in case notes.

b. The provider agency has 10 working days from receiving the CFC/PAS PCP form to amend the Service Plan, if necessary. The provider agency may complete the amendment with the member/PR over the phone. The amended service profile must be sent to the Plan Facilitator and member within 30 days. An amended Service Plan does not need to be signed by the member/PR or Plan Facilitator.

Note: If option 2 is selected, a coordinated meeting with the Plan Facilitator and provider agency oversight staff must occur within six months of the member beginning CFC/PAS services. This can be done at the member's next case management visit.